

**SAIH PROGRAM INTERAGENCY COMMUNICATION FORM**  
**For DHHS Approved Supported Housing Slots**  
**LME to DSS Eligibility**

**Date:**

**Purpose of Communication:**

- Report Change in Circumstance Information (ACH transition to Private Living)
- Request Gross Income Information
- Request SAIH Eligibility
- Release of Information is attached

**From:**  **LME/MCO Transition Coordinator**

**Name:**

**Title:**

Phone Number:

Email address:

LME/MCO Name:

LME/MCO Mailing Address:

City & Zip Code:

**To:**  **DSS**  
(County Name)

**CASE NAME:**

Medicaid ID #:

*The below question should be answered by the LME/MCO and provided to the DSS for ALL SAIH recertifications:*

Is the individual still eligible for and participating in the TCL program?    Yes    No    Date:

If 'No', indicate issue and action to be taken:

Other information:

Details of client discharge from ACH (projected date & private living address client  **has**  **will** move to):

**Report of Other Change**

Reported CHANGE:

**LMC/MCO Transition Coordinator Signature:** \_\_\_\_\_

**Date:**

**Title:**